NORTH CAROLINA DIVISION OF MH/DD/SAS

CURRENT CAP-MR/DD SERVICES*

(This package includes the current CAP-MR/DD waiver services from the CAP-MR/DD Manual dated 4/1/01.)*

1-12-04

FINAL DRAFT ***Please read the cover memo dated 1-15-04 prior to review of this document.**

NORTH CAROLINA DIVISION OF MH/DD/SAS

Current CAP-MR/DD Services

Table of Contents

6. CAP-MR/DD SERVICES

This section describes the services that are covered through CAP-MR/DD. When reviewing these CAP-MR/DD services, remember the following:

Services

- These services are for CAP-MR/DD recipients only.
- How much of each service a person will receive, how often it will be provided, and how long it will be provided must be included in the person's Plan of Care and approved by the local Lead Agency before payment is available.
- Payment may not be made for supplies and equipment received prior to approval.
- Cost limits for services apply to the State waiver year: April 1-March 31.
- Generally, only one service that directly involves the person is provided at a time. There are exceptions for Crisis Stabilization, Family Training, and Therapeutic Case Consultation- see the definitions and limitations for details.
- Waiver funding may be used only to cover the definitions covered in this section. The definitions do not address any named technique or therapy. These definitions have been written to meet general best practice habilitation principles and not to approve/deny any type of training. The decisions regarding techniques should be based on the needs/preferences of the person, the development of the Plan, the approval of that Plan, and in the end the conditions of waiver participation. The DMH/DD/SAS Client Rights Rules must be followed.
- Local Lead Agencies and Provider Agencies may not dictate the amount or type of service a person receives. Services should be determined through the development of the Plan of Care with the person's planning team and based on the needs of the person, the preferences of the person, the availability of other formal and informal supports, and rules of the funding source. Other parts of this manual contain the rules of this funding source.
- As a Medicaid recipient, the individual may also receive regular Medicaid services according to Medicaid policies and procedures. The policies may restrict the receipt of some regular Medicaid services by CAP-MR/DD participants. For example, a participant may not also receive another Medicaid-reimbursed Case Management service. See Section 7 for information about Medicaid's regular home and community care services.
- A child between the ages of seven and fifteen or a person enrolled in a public school system may receive no more than six hours of habilitative services per day when the school system is in operation per the calendar of the local Lead Education Agency. Other waiver recipients may receive no more than twelve hours of habilitative services per day. Exceptions to this rule require the approval of the DMH/DD/SAS Waiver Office. Habilitative services are Day Habilitation, Developmental Day Care, Supported Employment, and Supported Living Services.
- Medicaid will not pay for CAP-MR/DD services for a person who is a patient of a hospital, nursing facility, or ICF-MR facility.
- Back-up staff must be available if the regular direct service employee is unavailable and the lack of immediate care would pose a serious threat to health and welfare of the person.

Individual/Group Services

- Services that have a group rate are Day Habilitation, Respite, Supported Employment Services, and Periodic Supported Living Services. Group Services apply to situations involving one staff to two or more CAP-MR/DD recipients.
- All CAP-MR/DD Services/Supports are to be provided with a staffing ratio of one direct service employee to the person unless defined differently by the service definition or unless the service is provided in accordance with a group rate.
- If a waiver recipient receives a service with a group rate in a setting that two or more individuals receive that service at the same time of day, then the assumption is that the person will receive the service at the group rate.
- If the person requires an individual service with a staffing ratio of one direct service employee working exclusively with the person, then that must be justified in the person's Plan of Care according to the criteria in Appendix F. The MR-2, the NC SNAP and other evaluations must be consistent with the justification in the Plan of Care.
- If the person normally receives a group rate, then that rate must be billed regardless of the attendance of the other individuals in the group.
- When services are provided to a group of individuals, back-up staff must be available in the event of an emergency.

Provider Agencies/Staff Qualifications

- A CAP-MR/DD service may be billed only by an agency enrolled with Medicaid to provide that specific service. See Section 20 for provider enrollment information.
- Qualifications for Provider Agencies and staff, including competency/training requirements, are listed in Appendix G. Documentation forms for staff competencies are also included in Appendix G. Competency based training means that the training includes training objectives and methods of determining if the employee is competent in the required area(s). The Provider Agency maintains completed competency checklists in the employee's personnel file.
- Provider Agencies must comply with N.C. Administrative Code 10 14G, J, P-R, known as portions of Client Rights and Human Rights Rules respectively. This includes staff training and required written policies and practices. See Appendix G for training requirements for a) alternatives to and b) the use of physical restraint, seclusion, and isolation time out. See Appendix G for additional information about competency training requirements for these areas.
- Medical statements are required for CAP-MR/DD staff as indicated in G. A medical statement is a statement from a physician, nurse practitioner, or physician's assistant that indicates, at a minimum, the absence of any indication of active tuberculosis. Medical statements must be updated annually.
- Information about required criminal record checks is in Appendix G.
- Provider Agencies must maintain documentation/be able to demonstrate how the agency training of direct service employees covers the required training elements listed in Appendix G.
- Health care registry checks apply to all staff. The Health Care Registry can be accessed by calling 919-715-0562 or at www.ncnar.org on the Internet.
- Individuals who provide training to direct service employees for the core and client specific competencies must be a graduate from a college or university with a

baccalaureate degree and possess the knowledge to train in the specific content areas OR have an associate's degree in human services and two years of paid experience working with people with developmental disabilities OR have a high school diploma and four years of paid experience working with people with developmental disabilities. Approval by the DMH/DD/SAS Waiver Office for a Provider Agency's training staff is not required.

- Provider Agencies specify in their policies and procedures how they update healthcare registry, driver's license, and criminal background checks. For CPR, First Aid, and Bloodborne Pathogens/Universal Precautions, the recertification guidelines of the certifying body are followed.
- Agencies that provide services that require supervision of the direct service employee by Qualified Developmental Disabilities Professionals must have a system of privileging those QDDP staff. Minimum requirements for a QDDP are as follows: the individual must be a graduate of a college or university with a baccalaureate degree in a discipline related to developmental disabilities and have at least one year of supervised habilitative experience in working with individuals with developmental disabilities, or be a graduate of a college or university with a baccalaureate degree in a human service field and at least two years of supervised habilitative experience in working with individuals with developmental disabilities, or be a graduate of a college or university with a baccalaureate degree in a field other than one related to developmental disabilities and at least three years of supervised habilitative experience in working with individuals with developmental disabilities.
- A Provider Agency may not employ individuals who are legally responsible for the care and support of the waiver recipient as follows:
  - Parents or stepparents of a minor child may not provide services to their own child.
  - A spouse may not provide services to his/her own spouse.
  - A parent or stepparent of a minor child or a spouse may not own the Provider Agency that provides services to his/her own child/spouse.
  - A legal guardian may provide services to his/her own ward except as prohibited.
- Agencies providing CAP-MR/DD services must meet all rules governing the licensing and operation of such Agencies as specified by the Department of Health and Human Services, Division of Facility Services, the Division of Medical Assistance, and Rules for Mental Health, Developmental Disabilities, and Substance Abuse Facilities and Services, as applicable. DMH/DD/SAS manuals that contain rules that apply are listed in Appendix O-9 of this manual.
- Provider Agencies who accept Medicaid payment may not charge waiver recipients or their families any additional payment for services, supports, and/or equipment billed to Medicaid. This applies to all CAP-MR/DD services/supports and equipment, and regular Medicaid services, supports, supplies, and equipment. Provider Agencies of CAP-MR/DD Services may not require a waiver recipient or their family to sign an agreement that they will not change Provider Agencies as a condition of providing services to the waiver recipient.
- Training materials are included as part of the service, and are provided by the Provider Agencies of the habilitation services as long as they are of a reasonable cost. Habilitation Services include Day Habilitation; Developmental Day; Supported Employment; and Supported Living (only habilitation component). Personal items are expected to be purchased by the waiver recipient.

- Provider Agencies must make information about staff qualifications and training records, and direct service employee staff attendance/time records available for review by Local Lead Agencies except when prevented by law.

Service Location

- Provision of services is not contingent upon location unless the service definition itself requires that it be provided in a specific location such as institutional respite. The location of the service, including service-planning meetings scheduled by Lead Agencies, must be based on the needs of the person and not the needs of the Lead Agency, Provider Agency or direct service employee.
- For individuals living on counties bordering another state, the individual may receive services from an enrolled CAP-MR/DD Provider Agency who is within 40 miles of the border of the county.

Coordination with Educational Services

- CAP-MR/DD services are not offered during the school day while a child is attending school. The exceptional student's school day is the same as the students in general education unless otherwise specified in the Individualized Education Plan (IEP). If the child's Individual Education Plan indicates that the child's school day is less than that of other children in the school system, the child may receive **non-habilitative** CAP-MR/DD services during the normal operating hours of the Local Lead Education Agency. Requests for exceptions to this are submitted to the DMH/DD/SAS Waiver Office.
- Transportation to/from a child's home to/from school is the responsibility of the school system. No CAP-MR/DD Service may be billed to/from the home/school.
- For children who are receiving home schooling, the family will provide the home schooling enrollment certificate to the Case Manager and a schedule of dates/hours of operation of the home school. If the family does not provide the schedule to the Case Manager, the hours and dates of operation of the home school will be the same as the calendar that the local Lead Education Agency observes. If the child's home schooling schedule indicates that the child's school day is less than that of other children in the school system, the child may receive **non-habilitative** CAP-MR/DD services during the normal operating hours of the local Lead Education Agency. Requests for exceptions to this are submitted to the DMH/DD/SAS Waiver Office.
- CAP-MR/DD Services are not to be used as a replacement for educational services funded under IDEA.

Equipment and Supplies

- Equipment purchased with CAP-MR/DD funds belongs to the waiver recipient. Lead Agencies should note on their inventory records that the item purchased was transferred to the Waiver recipient.
- Repair of equipment covered under the Waiver (both for equipment purchased with Waiver funds and for equipment that would be included under a waiver service definition if purchased new) is covered as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment. If equipment was purchased with CAP-MR/DD funds and later requires replacement, a justification must be included, with an explanation of the need for the replacement/duplicate equipment included in the Plan of Care. The need for the replacement equipment

must be clear. Equipment is not covered if it is to be used for the convenience of care providers. This includes duplicate equipment requests because the person resides or visits in two households. Physician orders are not required for repairs of equipment but outcomes in the POC for the use of the equipment are included. The waiver recipient must own any equipment repaired.

- CAP-MR/DD funds may not be used to purchase or repair equipment or supplies to be used at the school for educational purposes.
- CAP-MR/DD equipment and supplies require a physician's order. The order must state that the equipment is "medically necessary:" however, a physician's order in itself does not make an item medically necessary in the context of Medicaid coverage. The order allows you to bill the item if it meets Medicaid criteria. See Service Definitions for specific approval criteria.
- Cost limits for equipment apply to the state waiver year: April 1- March 31.

Transportation

- When the provision of habilitative and support services includes transporting an individual into the community, Provider Agencies can bill for time transporting the individual. The individual's Plan of Care must indicate the provision of transportation, however outcomes are not necessary. Examples: Day Habilitation- transporting to and providing services the community college or YMCA; Supported Employment- transporting to and providing services at the job site. Provider Agencies cannot bill for time transporting individuals to licensed facility-based programs, such as ADVPs. Providers may not bill individuals transportation fees when transportation is included in the service definition.
- Transportation is a component of these service definitions: Day Habilitation; MR Personal Care Services, Supported Employment; and Supported Living Services. Transportation to and from a respite facility and or respite home is not included in the Respite Service definition. Transportation to/from activities during the provision of Respite Services may be billed under the Respite Service definition.
- Transportation to/from a child's home to/from school is the responsibility of the school system. No CAP-MR/DD Service may be billed to/from the home/school.

CAP-MR/DD Service Definitions

The CMS Common Procedure Coding System (CCPCS) code used to bill for the service is in parentheses. Provider Agency and direct service employee qualifications are in Section J. Specific limitations are shown. Beyond those limitations, there are other factors for the Case Manager to consider in Section 11 and Section 12. Section 17 contains the documentation requirements for each service. Appendix S contains information about exception criteria and approval criteria for services/equipment that is approved at the DMH/DD/SAS Waiver Office.

6.1 Adult Day Health Services (W8105)

Adult Day Health Services is a service furnished 4 or more hours per day on a regularly scheduled basis, for one of more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regiment" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's Plan of Care will be furnished as

component parts of this service. Services are provided in a certified Adult Day Health facility. This service is for adults who are aged, disabled, and handicapped who need a structured day program of activities and services with nursing supervision. It is an organized program of services during the day in a community group setting for the purpose of supporting an adult's independence, and promoting social, physical, and emotional well-being. Services must include health services and a variety of program activities designed to meet the individual needs and interests.

Limitations: This service may not be provided at the same time of day that a person receives:

Developmental Day Care	In-Home Aide
Interpreter	MR Personal Care
Respite Care	Supported Employment
Supported Living	Transportation

or one of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services, or individual therapies.

This service may not be provided on the **same day** as Day Habilitation Services.

NOTE: Transportation to/from the Adult Day Health Center is not a part of this service definition. Case Managers should refer individuals to the local DSS for Medicaid Medical Transportation for transportation needed to/from the Adult Day Health Care Center.

6.2 Augmentative Communication Devices (W8164-rental W8163-purchase)

These devices are necessary when normal speech is non-functional and when physical impairments make a gestural system impossible or ineffective. An aided system requires access to a symbolic system that is separate from the body. Selection of devices (and training outcomes for these devices) must be person specific and based on age, cognitive ability, fine and gross motor ability, environmental need and presence or absence of sensory impairment. The hardware and software needed to augment communication is divided into the following categories.

- Low Technology and Clinician-Made Devices
- High Technology, Commercially Available Dedicated Devices and Systems
- Standard Computer/Monitors and Operating Peripherals
- Computer Driven Devices, Operating Peripherals and Printers
- Mounting Kits and Accessories for each component
- Microphones
- Overlay Kits and Accessories
- Cassette Recorders
- Switches/Pointers/Access Equipment - all types, Standard and Specialized
- Keyboard/Voice Emulators/Key guards
- Voice Synthesizers

- Carrying Cases
- Supplies (Battery, Battery Charger)
- Power Strips
- Artificial Larynges

Note: Service and repair of purchased equipment is included when not covered by warranty. Service and repair of rented equipment is included in the rental payment. Repair of equipment may include equipment that was purchased through another funding source if the device would have been covered under the Augmentative Communication definition if purchased as new. This service does cover materials, devices, and aides used to create communication systems other than speech (sign language, picture exchange systems, voice output aides). Also covered are computers and software used for language development including written language development in the absence of functional oral language. Computer ribbons and batteries may be covered only when it can be demonstrated that the life expectancy of those items is consistent with the reasonable use of those items for use within the definition of augmentative communication. The cost of the printer ribbons and batteries will not be covered when the printer or device requiring batteries is used for purposes other than those stated in the augmentative communication definition.

Limitations: Medicaid does not cover service and maintenance contracts. This service definition does not cover speech therapy materials or fees for Internet access. The total cost of all Augmentative Communication devices cannot exceed $10,000.00 per Waiver year. See Waiver Supplies and Equipment for possible coverage of Speech Therapy materials.

Note: For a child who is enrolled in public schools or is in an age category that requires them to be enrolled in public schools or a home schooling program, the issue of the school's responsibility to fund Augmentative Communication, including items used for language development, should be considered. The child's Individual Education Plan will assist in making the determination of the school's responsibility to provide these items.

See Appendix B for details about providing these devices.

6.3 Case Management (W8188)

Case Management is a service that assists individuals who receive waiver services in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case Managers are responsible for ongoing monitoring of the provision of services included in the individual's Plan of Care. Case Managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of Plans of Care. Additionally, Case Management, for the purpose of discharge planning, may be provided while the recipient is in a hospital if it does not duplicate discharge planning activities and is provided up to 30 days prior to the recipient's discharge from the hospital. Case Management is a required service for all CAP-MR/DD funding recipients and is assumed ordered for all recipients. **The Case**

Manager is required to have at least one face-to-face contact with the waiver recipient each month. The Case Manager includes this contact in the Case Management monitoring schedule in the person's Plan of Care. The Case Manager is also responsible for following the other parts of the Case Management monitoring schedule. The Case Manager documents any deviation from the Case Management monitoring schedule in the case management documentation notes. Case Management activities outside of those indicated in the Case Management monitoring schedule must be reflected in the Action Plan of the Plan of Care.

Case Management is locating, obtaining, coordinating, and monitoring social, habilitative, and medical services as well as other services related to maintaining the person 's health, safety, and well-being in the community. The Case Manager's responsibilities are discussed throughout this manual in regard to specific topics. Primarily, they include:

- Coordinating and monitoring the screening of the CAP-MR/DD funding recipient to be sure that they are eligible for CAP-MR/DD participation;
- Obtaining input from the person/providers/significant others about the service delivery process and seeking information from anyone in an effort to obtain needed services/supports on behalf of the person;
- Developing the Plan of Care, preparing notices for planning team meetings, facilitating person-centered planning, circle of friends, mini-planning teams, revising the Plan as needed and securing approval of the Plan; and
- Informing significant others about the person's situation and the case manager's efforts on behalf of the person with the consent of the person/legally responsible person.

Note: CAP-MR/DD Case Management may not report Case Management billable hours at the same time of day an Area Program psychiatrist/therapist or direct enrolled Mental Health provider is billing Medicaid.

- Locating and coordinating sources of help from within the family and community so that the individual receives available natural and community supports. Completing application forms to assist in receiving community and other formal service supports.
- Facilitating the service delivery process, beginning with screening, and including the identification and procurement of services, on-going monitoring of care and services, and the annual reevaluation of the individual's needs and services. This includes making sure that the individual accesses the Single Portal Process as described in the Single Portal Rules.
- Monitoring the individual's situation to assure quality care as well as the continued appropriateness of the services and CAP-MR/DD participation, including review of documentation or providers, provider claims, and evaluation/progress summaries by providers. This includes observation of service delivery. See Section 15 for guidance on this.
- Observing the person's educational services, including attending IEP Meetings and school transition meetings, and referring/linking to services.
- Coordinating with Medicaid income maintenance staff regarding the individual's Medicaid eligibility and the meeting of applicable deductibles. This includes

planning with the income maintenance caseworkers, Provider Agencies, individuals, and families/primary caregivers on how deductibles will be met.

Caution: Writing reports to legal bodies for the purpose of accessing services/supports on behalf of the person, including preparing guardianship, limited guardianship, health care power of attorney, and/or mental health power of attorney application forms is not billable under CAP-MR/DD Case Management. Attending the guardianship hearing is also not billable under CAP-MR/DD Case Management.

Note: CAP-MR/DD Case Management does NOT include recruiting, training, or supervising staff. Those tasks are the responsibility of the Provider Agency. CAP-MR/DD Case Management does not include transporting individuals, purchasing equipment and supplies, and delivering equipment and supplies. Case Management does include the coordination and arranging of transportation and the coordination and arranging of purchasing equipment and supplies for Waiver recipients.

Note: Lead Agencies should provide the number of Case Management hours each month that the person needs, no more or less. The frequency of Case Management provided is determined by individual needs and situations and must be provided as specified in the Plan of Care. The assumption is that the number of Case Management hours will vary from person to person, with some individuals requiring less and some requiring more time.

Limitations: Lead Agencies may contract for Case Management Services. Agencies other than the Lead Agency may not provide Case Management and other Waiver services for the same person.

6.4 Crisis Stabilization: (W8161)

This support is a more intensive level of intervention service that provides close supervision to the person on an individual basis and assists during periods of time in which the person is presenting episodes of unmanageable and/or inappropriate behaviors, which require specialized staff intervention. An individual may display extreme, maladaptive behaviors that are not anticipated, are temporary in nature, and are beyond the daily behaviors, which are addressed through other supports.

It provides additional one-to-one supervision for the person as needed during an acute crisis situation so that the person can continue to participate in his/her daily routine without interruption. Crisis of this nature may be due to medication changes, reaction to family stress, or other trauma. By providing this service, an imminent institutional admission may be avoided while protecting the person from harming himself/herself or others.

While receiving this service, the person is able to remain in his/her place of residence, in the day program, or in respite care, while a crisis plan is developed and implemented. Crisis Stabilization staff will implement intervention plans as written by a psychologist and/or psychiatrist and which are directed at reducing the maladaptive behavior.

This service is offered in the setting(s) where the person receives services. This service may not be provided in a regional MR facility or in an ICF-MR community-based facility.

Crisis Stabilization is provided on an hourly basis for periods up to 14 consecutive days per episode. A Ph.D. psychologist or psychiatrist must order the amount and duration of the service with a new order for each episode.

Note: This service may be provided concurrently with the other Waiver services as approved in the individual's Plan of Care. This service may be included in the person's initial Plan of Care or annual Plan of Care update in anticipation that it may be needed, or it may be added during a crisis situation as a Plan Update/Cost Revision. The Case Manager must be notified of any use of Crisis Stabilization Services prior to use of the service if not approved on the Plan of Care and on the next working day if the service is already included on the Plan of Care. The local Lead Agency should have a provision in their Local Approval Plan for emergency use of Crisis Stabilization Services if this service is to be added in crisis situations.

Limitations: Crisis Stabilization is limited to 14 consecutive days per episode and cannot exceed 2016 hours per fiscal year. It may not be provided during the person's school program, in a hospital setting, or in an ICF-MR facility/Mental Retardation Center. Crisis Stabilization may not be provided on the same day as Respite Care-Institutional.

6.5 Day Habilitation: Periodic-Individual (W8196); Periodic-Group-2 clients (W8195); Periodic-2 or more clients (W8194)

Day Habilitation Services provide assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's Plan of Care. Day Habilitation Services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Plan of Care. In addition, Day Habilitation Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Note: Day Habilitation Services are provided as either group or individual services. A person may receive individual and group services on the same day but not at the same time of day. See Appendix F for criteria in determining if a person is to receive group or individual services. Day Habilitation Services are normally provided Monday-Friday but it is possible that a person's Day Habilitation programming will take place on weekend days. An example of an appropriate use of Day Habilitation Services on weekends would be to support a person's regularly scheduled volunteer activities. Day Habilitation Services includes transporting the person to/from the site of the Day Habilitation Service.

Limitations: This service may not be provided at the same time of day that a person receives:

Developmental Day Care	In-Home Aide
Interpreter	MR Personal Care
Respite Care	Supported Employment
Supported Living	Transportation

or one of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services, or individual therapies.

This service may not be provided on the **same day** that the person receives Adult Day Health Services.

Day Habilitation Services may not be provided in private homes, either the waiver recipient's or the private residence of any other individual, adult care homes, or group homes.

6.6 Developmental Day Care Services (W8130)

Developmental Day Care Services provides habilitation for preschool children and for school age children during non-school hours (before/after school and during school vacations). This service is designed to meet the developmental needs of the children in the areas of self-help, language and cognitive development, and psychosocial skills in order to facilitate their functioning in a less restrictive, more integrated settings. Requirements related to Part H of Individuals with Disabilities Education Act (IDEA), including the completion of an Individualized Family Service Plan (IFSP), and the provision of service coordination, must also be met.

The service is provided in a licensed day care facility, a licensed developmental day program, or program operated by the NC Public School System, and not in the home of the person's family. Medicaid funding is used only for the person and for no other family member. This service is viewed as a habilitation service and not a "baby-sitting" service. Any child care that is provided is secondary and only for the person. All Developmental Day Care Services are goal-directed with approved goals and objectives on the person's Plan of Care.

Limitations: This service may not be provided at the same time of day that a person receives:

Adult Day Health	Day Habilitation
In-Home Aide	Interpreter
MR Personal Care	Respite Care
Supported Employment	Supported Living
Transportation	

or one of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services, or individual therapies.

Note: Developmental Day Care Services may not be billed for school age children (kindergarten and above) in place of a public school placement. Developmental Day Care Services may be used for before/after school services for school-age children and during school vacations and on teacher work days, including school weather related make-up days, for before/after school care, and for make-up days scheduled for Saturdays.

6.7 Environmental Accessibility Adaptations (W8149)

Environmental Accessibility Adaptations are equipment and physical adaptations to the recipient's home which are required by the needs of the recipient as documented in the Plan of Care, as necessary to insure the health, welfare, and safety of the recipient, enable the recipient to function with greater independence in the home, and are direct and specific benefit due to the disability of the recipient. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installations of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Environmental modifications shall exclude those adaptations or improvements to the home which are not of direct and specific benefit to the recipient due to his/her disability, such as roof repair, plumbing, kitchen and laundry appliances, swimming pools, etc.

Environmental modifications include:

- Installation, maintenance, and repairs of ramps and grab bars;
- Widening of doorways/passageways for handicap accessibility;
- Modification of bathroom facilities including handicap toilet, shower/tub modified for physically involved persons, bedroom modifications to accommodate hospital beds and/or wheelchairs;
- Modification of kitchen counters, home fixtures, electric outlets, light switches, thermostats, shelves, closets, sinks, counters, and cabinets;
- Shatterproof windows;
- Floor coverings;
- Modifications to meet egress regulations;
- Alarm systems/alert systems including, auditory, vibratory, and visual to ensure the health, safety, and welfare of the person (includes signaling devices for persons with hearing and vision loss);
- Fences to ensure the health and welfare of a waiver recipient who lives in a private home and does not receive paid supervision 16 hours per day or more;
- Video cameras to ensure the health and welfare of a waiver recipient who must be visually monitored while sleeping for medical reasons, and who reside in a private home without paid supervision during sleep hours;
- Stair mobility devices;
- Barrier-free lifts/pulleys/mobility devices;
- Stationary/built-in therapeutic table;
- Modifications for therapeutic mobility exercises;
- Stationary ramp;
- Weather protective modifications for entrance/exits;
- Other requirements of the applicable life safety and fire codes.

The service reimburses for the purchase, installation, maintenance, and repair of environmental modifications and equipment. Repairs are covered when the cost is efficient compared to the cost of the replacement of the item.

Environmental modifications can only be provided as a waiver service when they are documented in the Plan of Care as necessary to meet the needs of the recipient, prevent institutionalization and payment is not available as part of a Medicaid state plan option.

In order to obtain approval for the requested Environmental Accessibility Adaptation, the following process is utilized:

- Assessment/recommendation by an appropriate professional that identifies the person's need(s) with regard to the Environmental Accessibility Adaptation(s) being requested. The Case Manager must insure that adequate/appropriate documentation is obtained to identify the person's needs, as well as types of adaptation required.
- Copy of the physician's signature certifying medical necessity is included with the request for Environmental Accessibility Adaptations. The physician may sign a statement on the assessment/recommendation certifying that the requested adaptation is medically necessary or may sign a separate document.
- Outcomes/goals related to training needs associated with the person/family's utilization and/or procurement of the requested adaptation(s) are included in the Plan of Care as appropriate.
- Copies of the information specified above, as well as a revised Cost Summary and Plan of Care Update/ Signature Page must be submitted to the approval agency in order to obtain approval of the requested Environmental Accessibility Adaptations.
- The Lead Agency maintains an invoice from the supplier/installer that shows the date the adaptation was provided to the person, a description of the adaptation and the cost including related charges (applicable charges for delivery, installation, and taxes). All services shall be provided in accordance with applicable State or local building codes. For adaptations that require permits for construction or installation, a receipt for the permit is required if the cost is claimed. Copies of the documentation related to these items are not submitted to the Local Approval Office or DMH/DD/SAS Waiver Office.

Limitations: The total cost of all Environmental Accessibility Adaptations provided in one year cannot exceed $2,500.00. This service is provided only for a recipient living in a private residence. Residences that are rented and not owned by the waiver recipient and/or the family of the waiver recipient may not be modified with Environmental Accessibility funds. The primary residence of the person may be modified, not a second home. Requests for fences and video cameras must be submitted to the DMH/DD/SAS Waiver Office for approval. This service cannot be used to purchase locks. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit.

6.8 Family Training (W8178)

This service provides training and counseling services for the families of individuals served through the waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does

not include individuals who are employed to care for the person. Training includes instruction about treatment regimens and use of equipment specified in the Plan of Care, and shall include updates as necessary to safely maintain the individual at home. All Family Training must be included in the individual's written Plan of Care.

Caution: Family Training may not be used to pay for the training of staff, such as the training of a Habilitation Technician, group home, or adult care home staff. If a foster parent or another individual eligible for Family Training is employed by an agency to provide services to the person, such as a foster parent employed as a Habilitation Technician, all of the training that the staff requires as an employee is part of the agency's overhead cost in providing the service. It may not be billed as Family Training.

Limitations: This service may be provided at the same time that the waiver recipient is scheduled to receive other waiver services. This service may not be utilized to enable family members to become qualified MR Personal Care employees or to cover routine training requirements of an agency if the family member is a paid direct service employee. This service may not be billed to cover the cost of conferences and group training opportunities, or travel and other associated per diem expenditures associated with attending conferences and training opportunities. Case Managers should assist family members in accessing other funding sources to support attendance at such conferences and training opportunities.

6.9 In-Home Aide Services - Level I (W8144)

In-Home Aide Services include general household activities, such as meal preparation and routine household care, provided by a trained Level I In-Home Aide, when the individual regularly responsible for these activities is temporarily absent or unable to carry out these activities. In-Home Aide Services at this level provide support to individuals and their families who require assistance with basic home management tasks, such as sweeping and mopping floors, dusting, making an unoccupied bed, cooking, shopping, paying bills, making minor household repairs, ironing and mending clothing.

Note: This is a temporary service and the person and the person's care provider may need referral for other on-going assistance if the care provider is determined to be unable to carry out these activities on an on-going basis.

Limitations: This service may be provided only in the private residence of the person. It **may not** be provided on the **same day** that the person receives Supported Living Services. In-Home Aide Services of more than 90 days duration in the person's waiver year require the approval of the DMH/DD/SAS Waiver Office. This service may not be provided at the same time of day that a person receives:

Adult Day Health	Day Habilitation
Developmental Day Care	Interpreter
MR Personal Care	Respite Care
Supported Employment	Transportation

or one of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services, or individual therapies.

6.10 Interpreter Services (W8189)

Interpreter Services is a service designed to provide effective, accurate, and impartial receptive and expressive interpreter and/or transliterating services for a waiver recipient who is deaf, hard of hearing, or deaf and blind, using any specialized vocabulary needed by that recipient. Interpreting is specific to the recipient's disability and denotes a skill in communication between sign language and spoken language. Transliterating denotes a skill in communication between spoken English and English-like signing or non-audible spoken English. Tactile interpreting or close vision services are also provided under this service.

Note: Only direct service to the recipient may be billed. Travel time, preparation time, and documentation time are not billable.

Limitation: The total reimbursement time under the Waiver cannot exceed 24 hours per Waiver year.

Limitations: This service may not be provided at the same time of day that a person receives:

Adult Day Health	Day Habilitation
Developmental Day Care	In-Home Aide
MR Personal Care	Respite Care
Supported Employment	Supported Living
Transportation	

or one of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services , or individual therapies.

6.11 Live- In Caregiver (W8191)

Live-In Caregiver Services provides reimbursement for the additional costs of room and board when a caregiver who provides approved Waiver services resides in the same household as the Waiver recipient.

Limitations: Reimbursement is not available to a caregiver who is related to the Waiver recipient by blood or marriage to any degree. Reimbursement is not available if the recipient lives in the caregiver's home or in a residence that is owned or leased by a Provider Agency of Medicaid services. The person may rent the residence from a family member if the family member does not live in the residence but may not rent the residence from the Provider Agency providing services to the person.

Note: The approved waiver services provided to the waiver recipient by the Live-In Caregiver are Supported Living and Personal Care Services. The Lead Agency bills Live-In Caregiver Services.

6.12 MR Personal Care Services (W8111)

MR Personal Care Services (MR PCS) include assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the Plan of Care, this service may also include such housekeeping chores as bedmaking, dusting, and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. In addition, ambulatory assistance and training in these tasks and medical monitoring such as monitoring vital signs; monitoring medications (note CAUTIONS below); recognizing and reporting symptoms of illness and changes in health conditions may be provided. The Personal Care direct service employee may function in a supportive role accompanying and facilitating the person's participation in day services and travel in the community (see CAUTIONS regarding travel for medical services).

Additional support in day services may be provided only when Medicaid is not reimbursing for the day service. MR Personal Care Services do not substitute for program staff, and the person must exhibit the following:

- Extreme deficits in motor functioning which prohibit the individual from participating in activities required in the day program, or
- Serious medical and/or physical involvement that impedes any participation in daily routines and necessitates assistance from another in order to participate, or
- Behavior that interferes with the routine of daily living or prevents the person from participating in the normal routine of daily living.

Cautions:

- Personal Care direct service employees may not administer medications - that is, decide what is the proper dosage to take at the proper time unless Medication Administration training has been successfully completed. The direct service employee may follow instructions from a responsible person/mentally competent person to assist the person in taking the medication or follow specific instructions from the primary caregiver in giving the person pre-measured medications at a specified time.
- Medical transportation, such as transporting a person to a physician's office, a clinic, or a hospital is not paid under MR Personal Care Services. Personal care services may not be billed when the direct service employee accompanies the person during medical transportation and medical visits. Medicaid covers medical transportation through other sources.
- The personal care tasks that an individual needs must be included in that person's Plan of Care.

- General supervision of the person is provided if the supervision is incidental in the provision of MR PCS.

Remember: The planning team should consider the needs of the person in deciding if the person needs MR PCS with nursing supervisory visits in consultation with a physician, physician's assistant, or registered nurse. If the person needs MR PCS with supervision by a licensed Home Care Agency, those supervisory visits are provided by a registered nurse to the person's place of service at least every 60 days. If the MR PCS direct service employee is supervised by a QDDP, these supervisory visits are made every month and the direct service employee must meet the Worker Qualifications for agencies certified by local Area MH/DD/SAS to provide MR PCS as defined in Appendix G.

Limitations: This service may not be provided on the same day that the person receives **Daily** Supported Living Services, regular Medicaid Personal Care Services, a Home Health Aide visit, or another substantially equivalent service. This service may not be provided in an adult care home. This service may not be provided at the same time of day that a person receives:

Adult Day Health	Day Habilitation
Developmental Day Care	In-Home Aide Services
Interpreter	Respite Care
Supported Employment	Periodic Supported Living
Transportation	

or one of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services, or individual therapies.

6.13 MR Waiver Equipment and Supplies (W8151)

MR Waiver Equipment and Supplies include devices, controls, or appliances, specified in the Plan of Care, which enable people to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

The service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct benefit to the person and without which the person would be institutionalized. All items shall meet applicable standards of manufacture, design, and installation.

The service includes the following items:

- **Category 1- Adaptive Positioning Devices:** Standers, trays, and attachments; prone boards and attachments; positioning chairs and sitters, trays and attachments; multi-function physiosystem, bolster rolls and wedges; motor activity shapes; therapeutic balls; visualizer ball; physio roll; therapy mats when used in conjunction with adaptive positioning devices.
- **Category 2-Mobility Aids:** Walkers, attachments, and accessories not on the regular Medicaid Durable Medical Equipment (DME) list; swivel wheeled scoot-about, adaptive car seats for physically involved people; lifts and lift systems not on the State DME list; customized/specialized wheelchairs/strollers, accessories and parts not on the DME list; repair of specialized/customized wheelchairs not on the State DME list; portable telescoping ramps; mobile wheelchair ramps; splints/orthotics for adults (including replacement materials and repairs); prosthetic/orthopedic shoes and devices for adults; protective helmet for adults that are medically necessary.

  Note: Mobility Devices for individuals ages 21 or younger, as defined by Children's Special Health Services, are requested through CSHS.

- **Category 3- Aids for Daily Living:** Adaptive eating utensils (cups/mugs, spoons, forks, knives universal gripping aid for utensils, adjustable universal utensil cuff, utensil holder, non-skid inner lip plate, sloping deep plates, scooper, plate guards, non-skid pads for plate/bowl, wheel chair cup holders); adaptive eating equipment (adaptive, assitive devices/aids including adaptive switches and attachments); mobile and/or adjustable tables for chairs, wheelchairs, and beds; adaptive toothbrushes; universal holder accessories for dressing, grooming, and hygiene; toilet trainer with anterior and lateral supports; adaptive toileting chairs and bath chairs and accessories not on the State DME list; adaptive hygiene/dressing aids; adaptive clothing; nondisposable clothing protectors; reusable incontinence undergarments with disposable liners for individuals age two and above; dietary scales; food/fluid thickener for dysphasia treatment; nutritional supplements that are taken by mouth such as those supplements covered by Medicaid for Home Infusion Therapy/Tube feedings; enclosed beds that are medically necessary and are not on the State DME list (see limitations below); bed rails; assitive listening devices for the individuals with hearing and vision loss (TDD, large visual display devices, Braille screen communicators, FM systems, volume control large print telephones, teletouch systems); medication dispensing boxes.

  Note: Switches for communication purposes are requested through the Augmentative Communication Service definition.

- **Category 4-Speech, Cognitive, Perceptual and Motor Developmental Treatment/Therapy Aids:** Specialized/adapted items necessary to improve visual-perceptual motor skills, improve integration processing abilities, improve communication abilities (that are not covered under the Augmentative Communication service definition), improve gross motor skills, develop reaching, and/or improve visual attention, focusing, and following.

In order to obtain approval for the requested MR Waiver Supplies and Equipment, the following is utilized:

- Assessment/recommendation by an appropriate professional that identifies the individual's need(s) with regard to the MR/DD Waiver Supplies and Equipment being requested. The Case Manager must insure that adequate/appropriate documentation is obtained to identify the person needs, as well as the specific supplies/equipment required. Diagnostic information must be consistent with the recommended supplies/equipment. The assessment/recommendation must state the amount of an item that the person needs. Supplies that continue to be needed at the time of the person's Continuing Need Review must be recommended in an annual re-assessment by an appropriate professional. The assessment/recommendation must be updated if the amount of the item the person needs changes.
- Copy of the physician's signature certifying medical necessity is included with the request for MR Waiver Supplies and Equipment. The physician may sign a statement on the assessment/recommendation certifying that the requested supply/equipment is medically necessary or may sign a separate document.
- Outcomes/goals related to the person/family's utilization and/or procurement of the requested supplies/equipment. If the equipment/supply is related to outcomes/goals already in the individual's Plan of Care, then this should be noted in the request for the equipment/supply. Outcomes must be consistent with the recommendation for the supplies/equipment.
- Copies of the information specified above, as well as a revised Cost Summary and Plan of Care Update/ Signature Page must be submitted to the Approval Agency in order to obtain approval of the requested MR Waiver Supplies and Equipment.
- The area program maintains an invoice from the supplier that shows the date the supply/equipment was provided to the individual, and the cost including related charges (applicable charges for delivery, taxes, etc.). Copies of the documentation related to these items are not submitted to the Approval Agency.
- If the supply requested is a need that continues into the person's new CNR year, then the information for continuation of that supply is updated and included in the person's new Plan of Care. This includes a new physician's statement of medical necessity.

Caution: Remember that supplies and equipment covered by regular Medicaid cannot be purchased under MR Waiver Supplies and Equipment (W8151). Consult your supplier to insure that supplies/equipment are not included on the Home Health Supply or DME lists. Refer to Section 7 for information about the coordination of ordering equipment and supplies for individuals age 21 and under.

Note: The CAP-MR/DD Case Manager coordinates the assessment and provision of Home Infusion Therapy (HIT) for the CAP-MR/DD waiver recipient, and includes the cost of HIT on the person's Cost Summary in the Medicaid column. A CAP-MR/DD Case Manager does not issue a service order for HIT. The supplier of HIT is responsible for training the caregiver with regard to HIT. The

person's physician decides on the type, frequency, amount, and method of HIT. Nursing supervision and/or training of the caregiver is not required.

Limitations: This service may not be used to purchase supplies and equipment available through regular Medicaid. Minor medical and surgical supplies routinely used in the care of the waiver recipient are not billed under this service definition. This service does not cover items that are for the convenience of care providers or training supplies required by a professional such as a journal to record the person's progress on goals/outcomes.

Remember: Enclosed beds must be submitted to the DMH/DD/SAS Waiver Office for approval.

6.14 Personal Emergency Response System (PERS) (W8162)

PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals, as specified in the Provider Qualifications Appendix G, staff the response center. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

This service pays the monthly service charge or monthly rental charge for a system that uses phone lines to alert a central monitoring facility of medical emergencies that threaten the individual's well being. This service may also alert the central facility of other situations that threaten the person's safety. The Provider Agency must be able to provide 24-hour coverage.

Limitation: This service does not pay for the purchase of equipment.

6.15 Respite Care

Respite Care is a service that provides periodic relief for a family or primary caregiver on an interim basis. It may not be used as a daily service in treatment planning. It must be used at irregular intervals if used as a periodic service. In order to be considered a primary caregiver, the person must be principally responsible for the care and supervision of the individual and must maintain his/her primary residence at the same address as the individual.

This service may be provided in the individual's home or in an out-of-home setting. The provision of respite care in terms of amount and location will be based on the individual's needs and may include day and overnight services.

Limitations: Respite Services may not be provided in group home settings, however the service can be provided in facility-based respite homes. Respite Services may not be billed when the Respite Provider Agency does not have an awake Respite worker on duty. Staff sleep time is not reimbursable. Individuals

residing in group homes and adult care homes can only receive Respite Services when visiting with family at their home. Individuals living alone or with a roommate cannot receive Respite Services. Respite Services may only be provided for the Waiver recipient; other family members, such as siblings of the recipient, may not receive care by the provider while Waiver Respite Services are being provided/billed for the recipient. Respite Services may not be provided by the recipient's primary care giver(s), parent(s), spouse, step-parent(s), foster parent(s), Supported Living provider or person who resides in the recipient's primary place of residence.

Private home Respite Services serving individuals are subject to licensure under G.S. 122 C, Article 2 when:

(1) more than two individuals are served concurrently; or
(2) either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.

Note: Recipients who are siblings may receive group Respite Services if the regulations regarding the provision of group Respite Services are followed. Respite services **may be provided** in facility-based Respite homes. Respite Services may be provided by the recipient's Supported Living worker when the worker does not have the same address as the Waiver recipient. Respite Services include transportation during the provision of Respite Services but not to/from a respite facility or private home respite location.

This service may be used to meet a wide range of needs, including family emergencies; planned special circumstances (such as vacations that the caregiver takes without the participant, hospitalizations of the person's non-paid caregiver, or business trips); relief from the daily responsibility and stress of caring for a special needs person; or the provision of time for the caregiver(s) to shop, run errands, and other tasks. In such instances, the service must be provided at irregular intervals. An individual who provides another CAP-MR/DD service to the recipient may be the respite direct service employee if he/she does not reside in the recipient's primary place of residence.

Planning teams should always consider if one of the other CAP-MR/DD service definitions could meet the needs of the person before utilizing the respite service definition. Choice of a particular Provider Agency may not be a reason for using respite services rather than another more appropriate waiver service definition.

Respite Services may not be provided for a person who loses his/her residential placement. However, if an individual is residing with his/her family (not to include foster family placement) and the family residence becomes uninhabitable for a temporary period of time, then Respite Services may be provided for this person.

Because Respite may not be used as a daily service in treatment planning, the following are situations in which Respite **may not** be provided:

- Every week-end during the person's Waiver year,

- On the same day/time of week for an indefinite period of time during the person's Waiver year,
- As a substitution for a regularly scheduled service, or
- Any other regularly scheduled service/support need.

Note: Case Managers and planning team members assist families with needs for regularly scheduled habilitation or personal care needs in looking at other CAP-MR/DD, community, and/or natural services/supports that may meet the individual's needs.

Respite may be used during teacher work days and/or school holidays but may not be used on an everyday basis during school summer vacations. Payment will not be claimed for the cost of room and board except when the service is provided in a facility approved by the State that is not a private residence.

This service may be provided on the same day that the person receives Supported Living Services.

An individual is expected to receive one-on-one staffing whenever the individual Respite rate is billed. If groups of Waiver recipients are receiving services in a facility or private home, the group rate should be billed unless the person meets the criteria for and receives individual Respite Services.

Limitations: This service may not be provided at the same time of day that a person receives:

Adult Day Health	Day Habilitation
Developmental Day Care	In-Home Aide
Interpreter	MR Personal Care
Supported Employment	Supported Living
Transportation	

or one of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services, or individual therapies. Lead Agencies approve up to 720 hours of respite services during the recipient's Waiver year. Requests for Respite Services over 720 hours during the year must be submitted to the DMH/DD/SAS Waiver Office.

Respite Services are available as Institutional, Non-Institutional Community-Based/Companion Based, and Non-Institutional Nursing Based as described below.

6.15.1 Respite Care-Institutional (W8118)

This is Respite Care provided in an ICF-MR bed in a State regional MR facility. This type of Respite Care is generally used when community-based services are not available to care for the person.

Limitations: Respite Care-Institutional may not be provided at the same time as Crisis Stabilization.

Except for Case Management Services, other CAP-MR/DD Services may not be billed on the day of admission to the Institutional Respite Facility but may be billed on the day of discharge.

6.15.2 Respite Care-Non-Institutional Community-Based/Companion (W8119-Individual; W8198-Group)

Respite Care-Non-Institutional Community-Based includes appropriately licensed, accredited, or authorized community-based respite programs. It includes care in a licensed/certified facility or private home of a direct service employee, and care provided through a certified companion sitter program.

Respite Care-Non-Institutional Community-Based/Companion Respite is provided as individual respite or group respite. The individual respite is always a staffing ratio of one respite direct service worker to one waiver recipient. The group respite ratio is billed when one respite direct service worker provides services to two or three Waiver recipients.

6.15.3 Respite Care-Non-Institutional Nursing-Based (W8181)

A registered nurse (RN) or licensed practical nurse (LPN) provides Respite Care-Non-Institutional Nursing-Based in a private home. See Section 7.7 for information about the provision of Private Duty Nursing.

6.16 Supported Employment (W8157 - Individual; W8158 - Group)

Supported Employment is paid employment for persons with developmental disabilities for whom competitive employment at or above minimum wage is unlikely and who, because of the severity of their disabilities, need intensive ongoing support to perform in a work setting. Supported Employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by individuals, including supervision and training. When Supported Employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision, and training required by individuals receiving Waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting. Medicaid payment may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- Incentive payments made to an employer of individuals in a Supported Employment program to encourage or subsidize the employer's participation in a Supported Employment program;

- Payments that are passed through to the individuals in a Supported Employment program; or
- Payments for vocational training that is not directly related to an individual's Supported Employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation services (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to Provider Agencies of the appropriate type of habilitation services.

Note: Supported Employment Services are provided as either group or individual services. A person may receive individual and group services on the same day but not at the same time of day. Supported Employment services furnished under the Waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142 (IDEA). A Case Manager must document that the service is not funded by Vocational Rehabilitation or the school system through formal correspondence with these agencies, obtaining copies of the person's educational or individual plan employment (IPE) by either agency, discussion with the Interagency Council; and/or documentation in Case Management notes of efforts to obtain funding for Supported Employment Services from either or both agencies prior to the authorization of CAP-MR/DD Supported Employment Services. The Case Manager assists the person in making application to the Division of Vocational Rehabilitation (DVR), if the services are not funded under IDEA. The Case Manager works with DVR and assists the person in explaining his/her preferences for employment, strengths, and needs. The Case Manager also works with the person and DVR in developing a plan to meet the person's needs. DVR requires that long-term support be identified prior to developing IPE that includes supported employment services. Supported Employment Services may be provided in settings where the recipient is the owner of the business, work enclave settings and mobile work crews when the individual's work program is not supported by other State funding.

Limitations: This service may not be provided at the same time of day that a person receives:

Adult Day Health	Day Habilitation
Developmental Day Care	In-Home Aide
Interpreter	MR Personal Care
Respite Care	Supported Employment
Supported Living	Transportation

or one of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services, or individual therapies. Supported Employment Services does not cover job development activities by the Provider Agency and/or assisting the individual with applying for

jobs. Individuals who need assistance with finding a job should be referred to the Division of Vocational Rehabilitation Services.

6.17 Supported Living (Level 1: W8182, Level 2: W8183, Level 3: W8184, Level 4: W8185, Periodic-Individual: W8199, Periodic-Group-W8197)

These services are provided in the community, the individual's own home, his/her family home, or settings which include small community integrated alternative care settings.

The supports that may be furnished to an eligible individual consist of the following: habilitation training and incidental personal assistance aimed at promoting the individual's acquisition, retention, or improvement of his/her skills in a variety of areas that directly affect one's ability to reside as independently as possible. Skill development includes:

Self-Care: Training or assistance in daily activities that enable a person to meet basic life needs such as food, hygiene, appearance, and health.

Independent Living: Training in activities that enable a person to participate in a full and varied life in the community such as meal preparation, home management, community resource utilization, and self-administration of medication.

Mobility: Training in activities that enable a person to move from one place to another in the home and community such as gross motor skills, fine motor skills, transfers, independent travel skills, and access/use of public transportation.

Socialization: Training in activities that enable a person to acquire new behaviors, increase fluency of skills, promote generalization of skills, and prevent regression of skill development.

Self-Direction: Training in activities that enable a person to manage and control his/her personal life such as decision making, initiation and follow-through of appointments, and self protection skills.

Transportation is provided as identified and needed for the accomplishment of goals and objectives established in the Plan of Care, and as designated to be addressed through Supported Living Services. All community resources will be exhausted prior to the cost of transportation being incorporated into the service provision. The cost of this transportation is included in the rate paid to the Provider Agency.

Remember: This service is not to be used to meet the transportation needs of an individual unless the transportation is related to the accomplishment of goals and objectives established in the Plan of Care.

Supported Living Services are supports needed for an individual in order for him/her to live in the community as independently as possible. Supported Living provides flexible, individually tailored supports and assistance to meet the

person's habilitation needs and to facilitate adequate functioning in their home and community. This habilitation service works towards meeting habilitative goals and objectives throughout the person's day and provides personal assistance that is **incidental** in nature.

Note: Supported Living Services may not be billed during medical transportation or when the Supported Living direct service employee accompanies the individual during such travel and/ or medical appointments. Medical transportation, such as transporting an individual to a physician's office is reimbursed through other Medicaid services.

Supported Living Services of four or more hours are provided at one of four levels. Appendix H defines the four levels of Supported Living, the hours associated with each level, and the criteria for each level as well as the implementation criteria. An exception may be submitted to the DMH/DD/SAS Waiver Office if the individual, his/her legal representative, and his planning team/circle of support believe that there are individual circumstances that warrant a consideration of a higher level of care than the one assessed by the criteria in Appendix H. Appendix H also contains information about situations that require a review of the person's Supported Living level by the DMH/DD/SAS Waiver Office. DMH/DD/SAS will make the decision regarding the special request. A Lead Agency, with the consent of the individual and/or his/her legal representative, may authorize the person to receive a level lower than the one correlated with the assessed SNAP score if natural supports, other funding sources, and/or other community resources are available to meet the needs of the person.

Individuals who live in non-private settings may receive up to 3.75 hours or less per day of periodic Supported Living Services. If a Provider Agency has a service order to provide a daily Supported Living Service, the Provider Agency is expected to provide the indicated average hours of service/supports to the waiver recipient, based on the Plan of Care developed that meets the person's needs and preferences. There could be situations when the hours are more or less than the planned amount based on the person's needs. For example the person may have a medical appointment, a need to spend time with his/her family, or need an extra hour or two of services/supports because other caregivers are not available. Such instances must be noted in the comments section of the standardized documentation form with the reason that the hours of service were more or less than planned. The daily rate will continue to be billed in such circumstances. The Case Manager monitors the delivery of Supported Living Services and revises the Cost Summary, if needed. Monitoring of hours is based on the use of Supported Living Services over a month rather than an evaluation of hours used on a particular day.

Individuals who live in private homes may need a service array that includes more than 3.75 hours of individual, periodic Supported Living Services rather than a daily rate. See Appendix H for information about the provision of periodic Supported Living Services to individuals who live in private homes. The Case Manager and Planning Team carefully examine the person's needs to determine if those needs can be met with one of the daily Supported Living Levels. If a daily Supported Living level will not meet the person's needs, the Case Manager and

the Planning Team may recommend that the person receive more than 3.75 hours of Individual Periodic Supported Living Services in conjunction with MR Personal Care.

Limitations: Daily and Periodic Supported Living may not be provided on the same day. Periodic Supported Living may be provided by two providers on the same day, but not at the same time of day, as long as all rules regarding the provision of Supported Living levels are followed, including the limitation of 3.75 hours of periodic Supported Living for individuals who live in non-private homes.

Limitations: Periodic Supported Living Services are provided as either individual or group. Individual and group services may not be provided at the same time of day but may be provided on the same day as long as they individual receives no more than the approved hours of periodic services associated with the Supported Living Utilization Rules. Periodic Supported Living Services may not be provided at the same time of day that a person receives:

Adult Day Health	Day Habilitation
Developmental Day Care	Interpreter
MR Personal Care Services	Respite
Supported Employment	Transportation

or one of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services, or individual therapies.

Periodic Supported Living Services **may be provided to a person on the same day, but not at the same time of day,** that they receive Adult Care PCS, In-Home Aide-Level I, or MR Personal Care Services.

Limitations: Daily Supported Living Services may not be provided at the same time of day that a person receives:

Adult Day Health	Day Habilitation
Developmental Day Care	Interpreter
Respite	Supported Employment
Transportation	

or one of the regular Medicaid services that works directly with the person, such as MH/DD/SAS Community Services or individual therapies.

Daily Supported Living Services may not be provided on the **same day** that a person receives:

Adult Care Personal Care
In-Home Aide-Level I
MR Personal Care
or regular Medicaid PCS and Home Health Aide visits.

6.18 Therapeutic Case Consultation (W8190)

Therapeutic Case Consultation provides the provision of expertise, training and technical assistance in a specialty area (psychology, behavioral analysis, therapeutic recreation, speech therapy, occupational therapy, physical therapy, or nutrition) to assist family members, caregivers, and other direct service employees in supporting individuals with developmental disabilities who have long term habilitative treatment needs. Under this model, family members and other paid/unpaid caregivers are trained by a licensed professional to carry out therapeutic interventions, which will provide consistency, therefore increasing the effectiveness of the specialized therapy. This service will also be utilized to allow specialists as defined to be an integral part of the treatment team by participating in team meetings and providing additional intensive consultation and support for individuals whose medical and/or behavioral/psychiatric needs are considered to be extreme or complex.

The activities addressed below are not covered under the State Plan but are covered under the Therapeutic Case Consultation definition.

Activities:

The activities outlined below take place with and without the person being present. These activities will be observed and assessed on at least a quarterly basis.

1. Observing the individual prior to the development/revision of the Support Plan to assess and determine treatment needs and the effectiveness of current interventions/support techniques.
2. Constructing a written Support Plan to clearly delineate the interventions and activities to be carried out by family members, caregivers and program staff. The Support Plan details strategies, responsibilities, and expected outcomes.
3. Training relevant persons to implement the specific interventions/supports techniques delineated in the Support Plan and to observe the person, to record data, and to monitor implementation of therapeutic interventions/support strategies.
4. Reviewing documentation and evaluating the activities conducted by family members, caregivers, or program staff as delineated in Support Plan with revision of that Plan as needed to assure continued relevance and progress toward achievement of outcomes.

   Note: This does not cover activities billable under the Case Management Service definition.

5. Training and technical assistance to family members, caregivers, and other individuals primarily responsible for carrying out the person's Plan of Care on the specific interventions/activities, delineated in Support Plan, outcomes expected and review procedures.
6. Participating in treatment team meetings.

Criteria

The need for Therapeutic Case Consultation must be clearly reflected on the individual's Plan of Care. Therapeutic Case Consultation may not include direct therapy provided to Waiver recipients, nor duplicate the activities of other services that are available to the individual through the Medicaid State Plan.

Note: This service is based on the needs of the individual as identified by the treatment team and indicated on the Plan of Care. Travel time, written preparation, and telephone communications are not billable as separate items. Therapists and paid para-professional caregivers are able to bill for their service concurrently. Training provided by the therapist to the QDDP is included in the habilitative service rate.

Limitation: The total cost reimbursable under the Waiver will not exceed $1,500.00 per Waiver year.

6.19 Transportation (W8192)

Transportation services are offered in order to enable individuals served on the waiver to gain access to waiver and other community services/activities specified in the Plan of Care. This service can be provided when documented in the Plan of Care as necessary in order for the individual to participate in an inclusive community life. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.

Limitations: This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation under the State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. This service is only available to individuals living in private residences. Additional Medicaid payment will not be provided to Provider Agencies to provide transportation to and/or from the person's residence and the site of a habilitation service when payment is included in the established rate paid the Provider Agency. In all cases, it must be clearly documented that without the use of this service, the individual would not have the opportunity to access to activities specified in the Plan of Care. Transportation services for recreational activities may be included only to the degree that they are not diversional in nature, and are included in the person's Plan of Care related to a specific therapeutic/habilitative outcome.

Limitations: This service may not be provided at the same time of day that a person receives:

Adult Day Health	Case Management
Day Habilitation	Developmental Day
In Home Aide	Interpreter
MR Personal Care	Supported Employment
Supported Living	

Limitation: The total cost reimbursable under the Waiver will not exceed $1,200.00 per Waiver year.

Note: Transportation from a child's home to school or from the school to the child's home is the responsibility of the public school system. The local Lead Agency bills transportation services.

6.20 Vehicle Adaptations (W8180)

Vehicle adaptations are devices, controls, or services which enable people to increase their independence or physical safety, and which allow the person to live in their home. The repair, maintenance, installation, and training in the care and use, of these items are included. Vehicle adaptations, repairs, and maintenance of equipment shall be performed by the manufacturer's authorized dealer according to manufacturer's installation instructions, and National Highway and Traffic Safety Administration guidelines. When appropriate, waiver recipients are referred to VR to acquire vehicle adaptations.

The following types of adaptations to the vehicle are allowable:

- Door handle replacements;
- Door height/width alterations;
- Installation of a raised roof or related alterations to existing raised roof systems to improve head clearance;
- Lifting devices;
- Devices for securing wheelchairs or scooters;
- Devices for transporting wheelchairs or scooters;
- Adapted steering, acceleration, signaling, and braking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training installed device is provided by certified personnel;
- Handrails and grab bars; and
- Lowering of the floor of the vehicle.

The cost effectiveness of the vehicle adaptations, relative to alternative transportation services, must be considered. Adaptations to vehicles are limited to vehicles owned by the person 's family and are limited to one vehicle. For purposes of this service, "family" is defined as the persons who live with or provide care to a recipient of Waiver services, and may include a biological parent, adoptive parent, step parent, foster family member, child, spouse, in-law, other relative, or domestic partner (in those jurisdictions in which domestic partners are legally recognized). "Family" does not include individuals who are employed to care for the person. Vehicle adaptations are only provided as a waiver service when they are documented in the individual's Plan of Care, required documentation is supplied, and the adaptation is necessary to avoid institutionalization.

Recipients are referred to VR when appropriate. They have staff who have expertise in assessing the needs of the person and making specific recommendations for the type of modification to meet the needs of the person with the vehicle. In the event that VR services are determined not to be an appropriate resource, the following process is utilized.

- All vehicles must be evaluated by an adapted vehicle supplier with an emphasis on safety and "life expectancy" of the vehicle in relationship to the modifications. Both VR and dealers have staff to provide this type of assessment.
- All equipment purchased through CAP-MR/DD funds will utilize a bid or competitive invoice process to insure the most efficient use of Medicaid funds.
- The recommended equipment or modification will be justified by an assessment from a Physical Therapist/Occupational Therapist specializing in vehicle modifications or a Rehabilitation Engineer or Vehicle Adaptation Specialist and accompanied by a physician's signature certifying medical necessity for the person. These assessments shall contain information regarding the rationale for selected modification, recipient pre-driving assessment if the CAP-MR/DD recipient will be driving the vehicle, condition of the vehicle to be modified, insurance on the vehicle to be modified, and training plan for the use of the prescribed modification.
- Documentation regarding each of the requirements specified above, as well as a revised Cost Summary and POC Signature Page must be submitted to the Lead Agency Local Approver in order to obtain prior approval of the requested Vehicle Adaptations.

Note: The modification must meet applicable standards and safety codes. Case Managers should inspect the completed adaptation from a health and safety perspective. The training plan for use of the modification shall be included in the individual's Plan of Care. The responsibility of the family keeping their insurance current is between the Department of Motor Vehicles and the family. Waiver funding will not be approved, however, to replace a lift if the family fails to keep their insurance current and needs payment for repairs of the equipment that would have been expected to be covered by insurance.

Note: Vehicle modifications do not cover the cost of the vehicle to be modified or the cost of rental of vehicles with adaptations on them. A family may choose to purchase a vehicle (new or used) that already has modifications on it. In such cases the process for approval of the adaptation remains the same. The price of the used lift on the used vehicle must be assessed and the current value (not the replacement value) may be approved under this service definition to cover this part of the purchase price. In such instances, the person/family may not take possession of the lift prior to being approved via the Lead Agency Approval Process.

Note: If paying for labor and costs of moving devices/equipment from one vehicle to another vehicle, then training on the use of the device is not required.

Limitation: The total cost of all vehicle adaptations provided in one year cannot exceed $10,000.00.